

Group Risk Personal Statement

June 2019

OnePath Life Limited (OnePath Life)

ABN 33 009 657 176 AFSL 238341

GPO Box 4129, Sydney NSW 2001

Energy Super

Phone 1300 4 ENERGY (1300 436 374)

Fax (07) 3229 7523

Email Insurance@energysuper.com.au

Website energysuper.com.au

Important notice

OnePath Life is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by OnePath Life
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by OnePath Life.

OnePath Life requires this Personal Statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement in the Product Disclosure Statement.

You may wish to seal it in an envelope and send it to:

Energy Super, PO Box 10530, Brisbane Adelaide Street QLD 4000

Policy owner's duty of disclosure

The policy owner enters into a life insurance contract in respect of your life and has a duty, before entering into the contract, to tell OnePath Life anything that it knows, or could reasonably be expected to know, may affect OnePath Life's decision to provide the insurance and on what terms.

The policy owner has this duty until OnePath Life agrees to provide the insurance.

The policy owner entering into the contract has the same duty before they extend, vary or reinstate the contract.

The policy owner entering into the contract does not need to tell OnePath Life anything that:

- reduces the risk OnePath Life insures you for
- is of common knowledge
- OnePath Life knows or should know as an insurer, or
- OnePath Life waives your duty to tell it about.

If you do not tell OnePath Life something that you know, or could reasonably be expected to know, may affect OnePath Life's decision to provide the insurance and on what terms, this may be treated as a failure by the policy owner to tell OnePath Life something that it must tell OnePath Life.

If the policy owner does not tell OnePath Life something

In exercising the following rights, OnePath Life may consider whether different types of cover can constitute separate contracts of life insurance. If it does, OnePath Life may apply the following rights separately to each type of cover.

If the policy owner entering into the contract does not tell OnePath Life anything the policy owner is required to, and OnePath Life would not have provided the insurance or entered into the same contract with the policy owner if they had told OnePath Life, OnePath Life may avoid the contract within three years of entering into it.

If OnePath Life chooses not to avoid the contract, it may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if the policy owner had told OnePath Life everything they should have. However, if the contract provides cover on death, OnePath Life may only exercise this right within three years of entering into the contract.

If OnePath Life chooses not to avoid the contract or reduce the amount of insurance provided, it may, at any time vary the contract in a way that places it in the same position it would have been in if the policy owner had told OnePath Life everything they should have. However this right does not apply if the contract provides cover on death.

If the failure to tell OnePath Life is fraudulent, OnePath Life may refuse to pay a claim and treat the contract as if it never existed.



Type of Fund/Plan

Please tick the appropriate box Group Life Group Salary Continuance

Policy number (if known)

Name of Fund/Plan

Type of cover

Death Only

Death and Total and Permanent Disablement (TPD)

Group Salary Continuance (monthly benefit)

Amount of required benefit/cover

\$, ,

\$, ,

\$, ,

1. Personal details

Title Mr Mrs Ms Miss Dr Other

Surname

Given names(s)

Date of birth (dd/mm/yyyy) / / Male Female

Residential address (this cannot be a PO Box)

Street

Suburb State Postcode

Country

Phone Home Work

Mobile

Email

May one of our underwriting staff or OnePath authorised service providers contact you by phone if we require more information?..... Yes No

If **yes**, when is the most convenient day(s) and time and on which phone number?

Days Time: From To Phone (H) (W) (M)

2. Residence and travel details

1. Are you currently residing in Australia?..... Yes No

If **no**, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian or New Zealand citizen or do you hold a visa that entitles you to reside permanently in Australia?..... Yes No

If **yes**, please proceed to question 3.

If **no**, please advise what type of visa you hold.

3. Do you have any intention of travelling outside Australia within the next two years?..... Yes No

If **yes**, please complete the following:

Date of departure (dd/mm/yyyy) / / Duration of stay Destination(s) (country/cities)

Purpose of stay Holiday Business Residing Other Please specify if **other**



3. Insurance details

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including OnePath Life (other than this application), including benefits under superannuation or insurance benefits by your employer? Yes No

If you have answered **yes**, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only) (dd/mm/yyyy)
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? Yes No

If **yes**, please provide name of company, alteration, date and reason (if known).

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? Yes No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

4. Occupation details

1. What is your usual occupation?

2. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed.
Sedentary/administration (e.g. filing, computer work, answering telephone, reception duties, etc.)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5kg, etc.)		
Manual work – heavy (e.g. bricklaying, lifting over 5kg, painting, carpentry, mechanic, etc.)		

3. How many hours (on average) do you work per week in your principal occupation (include hours worked at home)?.....

4. What is your current annual income earned through personal exertion, before tax, and including superannuation contributions, but after deduction of business expenses? \$, ,

5. Do you have more than one occupation? Yes No

If **yes**, please specify the occupation, your normal duties and the average hours you work per week in each of your other occupation(s):

5. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? Yes No
2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc.? Yes No
3. aviation/flying, other than as a fare-paying passenger? Yes No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity.

Motorcycle/motor racing

Do you have a Motorcycling Australia (MA), FIM international or similar license? Yes No

Vehicle type Races p.a.

Engine size Max. speed (km/h) Class Recreational Amateur Professional

Scuba/skin diving

Average depth (m) Maximum depth (m) Dives per annum

Do you use explosives? Yes No Do you dive in caves or potholes? Yes No

If **yes**, give details.

Football/Soccer/Aussie Rules, etc.

Code played and grade

Games p.a. Recreational Amateur Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc.? Yes No

If **yes**, provide amount and details.

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? Yes No

If **yes**, state type and period held.

Do you intend to change the scope of your present licence? Yes No

Have you ever had an accident or been charged with violating CASA regulations? Yes No

Do you always use authorised landing areas? Yes No

Please complete the table below.

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Charter	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Private	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Aero club/flying school	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Agriculture	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Helicopter	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ultralight aircraft	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? Yes No

If **yes**, please provide frequency and details.

Other sports or pastimes

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.).

b. On what basis do you partake in this activity? Recreational Amateur Professional

6. Personal statement

1. What is your current height and weight? Height (cm) Weight (kg)

2. Has your weight varied by more than 10 kg during the last 12 months (excluding pregnancy)? Yes No

If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance or used any form of electronic cigarette? Yes No

If **yes**, please state **type** and **quantity** per day.

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.) or anti-smoking medication (e.g. Zyban, Chantix, etc.)? Yes No

If **yes**, please state **type(s)** used and **length of time** you have been using this.

5. Non-smokers – have you ever smoked regularly in the past? Yes No

If **yes**, please state **type**, **quantity** per day and date ceased.

6. Do you consume alcohol? Yes No

If **yes**, please state how many standard drinks you consume **per day** (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

7. Have you ever been advised to stop or reduce your alcohol intake due to a medical condition? Yes No

If **yes**, please provide full details.

If you are required to have a full medical examination, go to Section 9 on page 9.

7. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? Yes No

2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)? Yes No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Note: You are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, brothers, sisters).



8. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. **Asthma?** Yes No
2. **High blood pressure?** Yes No
3. **High cholesterol?** Yes No
4. **Diabetes?** Yes No
5. **Stress, anxiety, depression or any other mental health condition?** Yes No
6. **Back or neck pain, sciatica or any disorder of the spine or neck?** Yes No
7. **Arthritis, shoulder or knee pain or any other disorder of the joints?** Yes No
8. **Cyst, mole or skin lesion?** Yes No

If you answered **yes** to any of the conditions in **bold** above, please complete the relevant questionnaire on pages 12 to 20.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? Yes No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? Yes No
11. Thyroid or glandular trouble? Yes No
12. Ulcers or recurring indigestion? Yes No
13. Epilepsy, fits or dizziness, fainting of any kind or persistent headaches? Yes No
14. Alzheimer's disease or dementia? Yes No
15. Kidney, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? Yes No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? Yes No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? Yes No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? Yes No
19. Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders? Yes No
20. Any abnormality affecting eyesight, hearing or speech? Yes No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment?) Yes No
22. Anaemia, haemophilia or any other disease of the blood? Yes No
23. Bowel, liver or gall bladder disease or hepatitis? Yes No
24. Coughing of blood or passing of blood from the bowel or in the urine? Yes No
25. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? Yes No
26. Due to injury or illness have you ever been off work for more than seven consecutive days (**if not already mentioned**)? Yes No
27. Do you now have any symptoms of ill health or disability? Yes No
28. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc.) Yes No
29. Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis? Yes No
30. Have you **ever** used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence? Yes No
31. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? Yes No
32. Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related condition? Yes No
33. Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis? Yes No

- 34.A** Is the combined total of your existing insurance(s) detailed in section 3 Question 1, and any new insurance you are applying for with OnePath Life, more than any one of the following; \$500,000 Death; \$500,000 TPD; \$200,000 Trauma; \$4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover? Yes No

If you answered Yes to question 34(A) please proceed to 34(B), otherwise continue to question 35

- 34.B** Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (please do not include any test conducted solely for the purpose of medical research study and where the result of the test has not been or will not be, provided to you). Yes No

35. Females only

- a. Have you ever had any complications with pregnancy or childbirth? Yes No
- b. Are you now pregnant? If **yes**, please advise due date (dd/mm/yyyy) / / Yes No
- c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? Yes No
- d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? Yes No

If you answered **yes** to any questions from 9–35, please complete the following table. If there is not enough space here, please provide details on page 21.

Question number	<input style="width: 100%;" type="text"/>		
Disability, illness, injury or condition	<input style="width: 100%;" type="text"/>		
Investigation type(s) and result(s)	<input style="width: 100%;" type="text"/>		
Date of first symptoms (dd/mm/yyyy)	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>	Frequency of symptoms	<input style="width: 100%;" type="text"/>
Type of treatment	<input style="width: 100%;" type="text"/>		
Date treatment provided and ceased (dd/mm/yyyy):	From <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>	to	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>
Has further treatment, referral or investigation(s) been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Time off work	<input style="width: 100%;" type="text"/>		
Have you completely recovered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last symptoms (dd/mm/yyyy)	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>
Name and address of medical facility and attending doctor	<input style="width: 100%;" type="text"/>		
	<input style="width: 100%;" type="text"/>		

Question number	<input style="width: 100%;" type="text"/>		
Disability, illness, injury or condition	<input style="width: 100%;" type="text"/>		
Investigation type(s) and result(s)	<input style="width: 100%;" type="text"/>		
Date of first symptoms (dd/mm/yyyy)	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>	Frequency of symptoms	<input style="width: 100%;" type="text"/>
Type of treatment	<input style="width: 100%;" type="text"/>		
Date treatment provided and ceased (dd/mm/yyyy):	From <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>	to	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>
Has further treatment, referral or investigation(s) been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Time off work	<input style="width: 100%;" type="text"/>		
Have you completely recovered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last symptoms (dd/mm/yyyy)	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>
Name and address of medical facility and attending doctor	<input style="width: 100%;" type="text"/>		
	<input style="width: 100%;" type="text"/>		

Question number	<input style="width: 100%;" type="text"/>		
Disability, illness, injury or condition	<input style="width: 100%;" type="text"/>		
Investigation type(s) and result(s)	<input style="width: 100%;" type="text"/>		
Date of first symptoms (dd/mm/yyyy)	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>	Frequency of symptoms	<input style="width: 100%;" type="text"/>
Type of treatment	<input style="width: 100%;" type="text"/>		
Date treatment provided and ceased (dd/mm/yyyy):	From <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>	to	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>
Has further treatment, referral or investigation(s) been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Time off work	<input style="width: 100%;" type="text"/>		
Have you completely recovered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last symptoms (dd/mm/yyyy)	<input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/> / <input style="width: 100px;" type="text"/>
Name and address of medical facility and attending doctor	<input style="width: 100%;" type="text"/>		
	<input style="width: 100%;" type="text"/>		

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yyyy) / / Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yyyy): From / / to / /

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yyyy) / /

Name and address of medical facility and attending doctor



9. Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre

Phone

No. and street

Suburb/Town State Postcode

2. How many years have you been attending this doctor/medical centre?..... Years Months

a. When was your last visit to this doctor/medical centre?	b. Reason for check-up or consultation?	c. Outcome including medication, treatment etc.	d. Degree of recovery?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> %

3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned?..... Yes No

If **yes**, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc.
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>

10. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement (including all questionnaires in this form that appear after this declaration) signed by me and given to OnePath Life and/or the Medical Examiner are true and correct.
- I have read the Privacy Statement at Section 12 of this form (below). (OnePath's Privacy Policy details how we manage personal information. It is available at onepath.com.au/insurance/privacy-policy)
- I acknowledge and consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Privacy Statement on this form (see Section 12).
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I understand my duty of disclosure and the remedies available to OnePath Life if I fail to comply with my duty of disclosure under the Insurance Contracts Act 1984. I understand that my duty of disclosure continues after I have completed this application until I am notified in writing that my application for insurance has been accepted.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to OnePath Life in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Product Disclosure Statement(s) (PDS) for the type(s) of cover for which I am applying.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by OnePath Life.

Signature of life insured/applicant

Date (dd/mm/yyyy) / /



11. Authorisations

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured	<input type="text"/>	Date of birth (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Signature of life insured	<input checked="" type="text"/>	Date (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Address of life insured	<input type="text"/>		
Suburb/Town	<input type="text"/>	State	<input type="text"/>
Postcode	<input type="text"/>		
Policy number	<input type="text"/>		

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured	<input type="text"/>	Date of birth (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Signature of life insured	<input checked="" type="text"/>	Date (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Address of life insured	<input type="text"/>		
Suburb/Town	<input type="text"/>	State	<input type="text"/>
Postcode	<input type="text"/>		
Policy number	<input type="text"/>		

12. Privacy Statement

In this section 'we', 'us' and 'our' refers to OnePath Life Limited. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information (including health and other sensitive information) from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information (including health and other sensitive information). Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from onepath.com.au/insurance/privacy-policy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information (including health and other sensitive information) to certain third parties as outlined below.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information (including health and other sensitive information) include:

- an organisation that assists us to detect and protect against consumer fraud;
- any related company of OnePath Life Limited which will use the information for the same purposes as OnePath Life Limited and will act under OnePath Life's Privacy Policy;



- organisations performing administration and/or compliance functions in relation to the products and services we provide;
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- our solicitors or legal representatives;
- organisations maintaining our information technology systems;
- organisations providing mailing and printing services;
- persons who act on your behalf (such as your agent or financial adviser);
- the policy owner (or parties acting on behalf of the policy owner);
- regulatory bodies, government agencies, law enforcement bodies and courts;
- our related companies (members of the Zurich Insurance Group Ltd group), including for carrying out any group business functions;
- organisations, including those in alliance with us or our related companies, to distribute, manage and administer our products and services, carry out business functions and analytics activities.

We will also disclose your personal information (including health and other sensitive information) in circumstances where we are required by law to do so. Examples of such laws are:

- the *Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- there are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Information required by law

OnePath Life Limited may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at onepath.com.au/insurance/privacy-policy

Privacy consent

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions please notify us in writing.

If you give us personal information about someone else, you must show them a copy of this document or our Privacy Policy available at onepath.com.au/insurance/privacy-policy so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

Privacy Policy

Our Privacy Policy contains information about:

- when we may collect information from a third party;
- how you may access and seek correction of the personal information (including health and other sensitive information) we hold about you; and
- how you can raise concerns that we have breached the Privacy Act or an applicable code and how we will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing:
GPO Box 75
Sydney NSW 2001

Email: Insuranceprivacy@onepath.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 133 667.

More information can be found in our Privacy Policy at onepath.com.au/insurance/privacy-policy

Overseas recipients

We may disclose your personal information (including health and other sensitive information) to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in our Privacy Policy at onepath.com.au/insurance/privacy-policy

13. Supplementary questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in Section 8.

1. When did you have your first episode of asthma?Date (dd/mm/yyyy) / /

2. When was your most recent episode of asthma?Date (dd/mm/yyyy) / /

3. Approximately how many episodes have occurred in the last 12 months?

4. Have you ever suffered from nocturnal asthma attacks?..... Yes No

If **yes**, please provide the frequency of these attacks and approximate date of last attack.

5. Have you had any time off work due to this condition? Yes No

If **yes**, please provide the dates and duration.

6. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)?..... Yes No

If **yes**, please provide details.

7. Have you sought medical treatment or advice for asthma?..... Yes No

If **yes**, please provide details.

Name of doctor/health professional

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) / /

8. How has your doctor described your asthma? Mild Moderate Severe

9. Have you ever used any medication, including steroids?..... Yes No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

10. Have you ever been hospitalised due to asthma? Yes No

If **yes**, please provide details.

Date from (dd/mm/yyyy) / / Date to (dd/mm/yyyy) / /

Name and address of hospital.

11. Have you ever had lung function tests performed?..... Yes No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

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Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in Section 8.

1. When was your high blood pressure first diagnosed? Date (dd/mm/yyyy) /
2. What was your blood pressure reading at that time? Systolic Diastolic
3. Have you ever been treated by medication? Yes No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>

4. Did you undergo any tests or investigations? Yes No

If **yes**, please provide details.

Tests performed	Date (dd/mm/yyyy)	Results
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>

5. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy) /

6. What was the date of your last blood pressure check? (dd/mm/yyyy) /
7. What was your blood pressure reading at that time? Systolic Diastolic
8. How has your doctor described your blood pressure control? Excellent Good Poor Other

If **other**, please provide details.

9. What is the date of your next blood pressure check-up? Date (dd/mm/yyyy) /



Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in Section 8.

1. When was your high cholesterol first diagnosed? Date (dd/mm/yyyy) / /

2. What were your cholesterol readings at that time? Cholesterol Triglycerides
 HDL Cholesterol LDL Cholesterol

3. Did you undergo any tests or investigations? Yes No

If **yes**, please provide details.

Tests performed	Date (dd/mm/yyyy)	Results
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

4a. Have you ever used any medication? Yes No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? Yes No

If **yes**, please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation / /
(dd/mm/yyyy)

6. What was the date of your last cholesterol check? Date (dd/mm/yyyy) / /

7. What were your cholesterol readings at that time? Cholesterol Triglycerides
 HDL Cholesterol LDL Cholesterol

8. How has your doctor described your cholesterol control? Excellent Good Poor Other

If **other**, please provide details.

9. What is the date of your next cholesterol check-up? Date (dd/mm/yyyy) / /



Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in Section 8.

1. What type of diabetes were you diagnosed with?

2. When was your diabetes first diagnosed?Date (dd/mm/yyyy)

 / /

3. How is your diabetes controlled?

Insulin – go to question 3

Diet only – go to question 4

Oral – list medications below and then go to question 4

4. How many times a day do you administer insulin? I'm on an insulin pump One or two times daily Three or more times daily

5. How often do you monitor your sugar levels? One or two times daily Three or more times daily Other

If **other**, please provide details.

6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease

or eye problems (not already mentioned in the Personal Statement), or protein in the urine? Yes No

If **yes**, please provide details.

Condition	Date (dd/mm/yyyy)	Treatment
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? Yes No

If **yes**, please provide details.

Date (dd/mm/yyyy)	Test results
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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Is this result consistent with others taken over the last 12 months? Yes No

If **no**, please provide details.

Date (dd/mm/yyyy)	Test results
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
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8. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation / /

(dd/mm/yyyy)



Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in Section 8.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- Anxiety including generalised anxiety, panic or phobia disorder
- Eating disorder including anorexia nervosa or bulimia
- Depression including major depression or dysthymia
- Manic depressive illness or bi-polar disorder
- Alcohol or other substance abuse or addiction
- Post traumatic stress
- Schizophrenia or any other psychotic disorder
- Stress, sleeplessness or chronic tiredness
- Other

If **other**, please describe.

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)
<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	/ /	/ /
<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	/ /	/ /
<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	/ /	/ /
<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	/ /	/ /

3. Have you ever had any recurrence of the symptoms?..... Yes No

If **yes**, please provide details including dates.

4. Are you currently symptom free?..... Yes No

5. Date of last symptoms.....

6. Have you ever attempted suicide or self harm?..... Yes No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

7. Are you aware of the cause or reason for your condition(s)?..... Yes No

If **yes**, please provide details.

8. Have you ever had any time off work due to your condition(s)?..... Yes No

If **yes**, please provide the dates and duration.



9. Are you currently or have you ever been on treatment, including medication? Yes No

If **yes**, please provide details.

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

10. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life?..... Yes No

If **yes**, please provide details.

11. Have you been referred for consultation with a psychiatrist or psychologist?..... Yes No

If **yes**, please provide details.

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation / /
(dd/mm/yyyy)

12. Have you been admitted to hospital or any other care facility?..... Yes No

If **yes**, please provide details.

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation / / Doctor(s) consulted
(dd/mm/yyyy)



Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in Section 8.

1. When did your back/neck condition first occur?Date (dd/mm/yyyy)

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? Yes No
 If **yes**, please provide details.

Tests	Date of tests (dd/mm/yyyy)	Results
<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>
<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>

6. Have you had recurrent or multiple episodes of the back/neck condition? Yes No
 If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
<input type="text"/>	<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text" value=" / /"/>	<input type="text"/>

8. Have you had any time off work due to this condition? Yes No
 If **yes**, please provide the dates and duration.

9. Are your work duties or activities limited/affected by the condition?..... Yes No
 If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind?..... Yes No
 If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is:..... Resolved Improving Stable Deteriorating

12. What was the date of your last symptoms?.....Date (dd/mm/yyyy)

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in Section 8.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	If other , state which joint <input style="width: 100px;" type="text"/>		

2. When did this condition first occur? Date (dd/mm/yyyy) / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? Yes No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition? Yes No

If **yes**, please provide the dates and duration.

8. Do you have any residual pain, limitation of movement or restriction of any kind? Yes No

If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition?..... Yes No

If **yes**, please provide details.

10. Are you still undergoing treatment? Yes No

If **yes**, please provide details.

11. Overall do you feel that your condition is:..... Resolved Improving Stable Deteriorating

12. What was the date of your last symptoms?..... Date (dd/mm/yyyy) / /



Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in Section 8.

1. Please provide details in the table below.

Site (e.g. back, left leg)	Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? Yes No

If **yes**, please provide details for each Date of removal (dd/mm/yyyy)

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow-up since the original removal?..... Yes No

If **yes**, please provide details and advise how often follow-up is required.

4. Have you had any other tests, investigations or treatments not mentioned above? Yes No

If **yes**, please provide details.

Tests/Treatments/Investigations	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor?..... Yes No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation (dd/mm/yyyy)



Additional information/comments

[Empty rectangular box for additional information/comments]



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